DHCS Department of Health Care Services

DHCS use
Received:
Completed:

Electronic Funds Transfer (EFT) Registered User Enrollment Form

Section I

General Information- (All fields required except E if applicable)

A. Beneficiary/ Provider/ Case Name:	**B. DHCS Account #:** (Refer to Instructions page for format)
C. Mailing Address: (*Number, Street, City, State, Zip code)*	
D. Email Address: (Review for accuracy)	**E. Personal Representative/ Contact Person:** (*If applicable*)

Notice: This document is for DHCS internal use only and will not be shared with other entities.
Information provided in this section will only be used for account validation and enrollment in the EFT Registered User option by DHCS staff and its authorized financial institution.
By providing your email address you agree to receive and accept communications regarding EFT via email.

Section II

Authorization

Please read the following Authorization Agreement:

Automated Clearing House (ACH) Debit- I hereby authorize designated Financial Agents of the Department of Health Care Services (DHCS), Third Party Liability and Recovery Division (TPLRD) to initiate debit entries to the financial institution account that I saved in my Registered User Account, for payments owed to the DHCS TPLRD upon my request (beneficiary/ provider) or my representative, using ACH debit method.

Automated Clearing House (ACH) Credit- I hereby authorize the Electronic Funds Transfer (EFT) contact person and the financial institutions involved in processing my EFT payments to receive this confidential information necessary for enrollment in the Registered User option.

- I authorize the disclosure of my individually identifiable information as described above for the purpose described.
- If I sign this authorization to use or disclose information, I can revoke that authorization at any time, in writing. The revocation will not affect information already used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A. Beneficiary/ Provider Representative/ Contact Signature	**B. Date**

(Refer to the instructions on reverse)

Instructions:

Section I - General Information (All information must be completed, except E.)

A. **Beneficiary/ Provider/ Case Name:** Enter the complete Medi-Cal Beneficiary or Provider name as shown on DHCS invoice or correspondence. For Estate Recovery, enter the Estate or Case Name.

B. **DHCS Account Number:** To help in processing payments to the correct account, an identifier is added at the beginning of the Beneficiary's Client Index Number (CIN), or the Provider's National Provider Identifier (NPI). Please include the identifier to your account number on the enrollment form.
   1. **Working Disabled Program**: D + CIN (ex: **D**98765432A)
   2. **Estate Recovery**: P + CIN + sequence# (ex: **P**98765432A-001)
   3. **Personal Injury**: C + CIN + sequence# (ex: **C**98765432F-001)
   4. **Overpayments**:
      Providers: V + NPI + sequence# (ex: **V**9876543210-001)
      Beneficiaries: B + CIN + sequence# (ex: **B**987654321-001)
      State Share: G + NPI + sequence# (ex: **G**DME02402F-001)
   5. **Quality Assurance Fee** :
      Skilled Nursing Facilities: Q + SNF + NPI (ex: **QSNF**9876543210)
      Intermediate Care Facilities: Q + ICF + NPI (ex: **QICF**9876543210)

C. **Mailing Address:** Enter your mailing address where DHCS correspondence and forms should be sent.

D. **Email Address:** Enter your email address and review to make sure that it is correct.

E. **Personal Representative/ Contact Person:** Enter name of the authorized personal representative of the beneficiary, or the name of the contact person for a Provider or Estate.

- If you are an authorized personal representative for a beneficiary (e.g. legal guardian, conservator, etc.), please provide proof of authority to sign on behalf of the beneficiary (e.g. letters of conservancy, court order, etc.)

Section II - Authorization – This section must be completed.

A. Signature: The beneficiary or the provider's contact person must sign the form to indicate participation in the EFT Registered User option and agreement with the terms and conditions.

B. Date: Enter the date the form is signed.

Send the completed enrollment form by using the enclosed prepaid envelope or by mailing to:

Department of Health Care Services
TPLRD ASU EFT Admin, MS 4718
P.O. Box 997425
Sacramento, CA 95899-7425

By enrolling in the Registered User option, payments are not automatically deducted from your bank account. Registered Users are responsible for logging in and scheduling payments to DHCS.

If you need to make payment(s) immediately, please visit www.paycalifornia.com and use the Just Pay It Option.